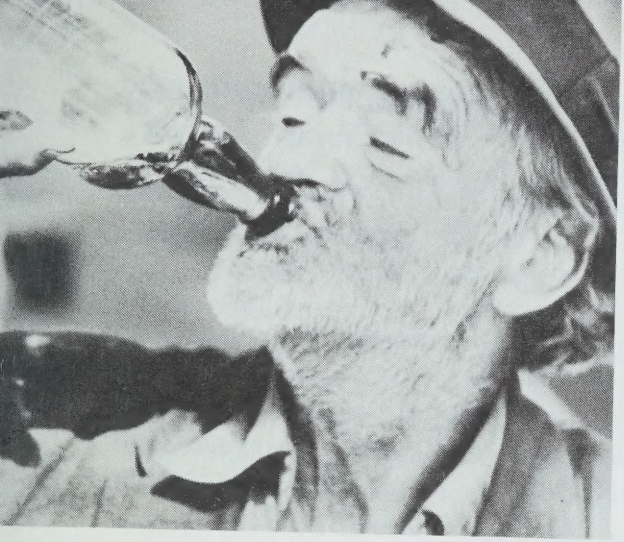
Substance Abuse among the Elderly

by Judy Dobbie



PHOTOS BY JUDY DOBBIE

Grow old along with me!
The best is yet to be.

The frail and crooked old lady slumped in the wheelchair is my great-aunt. She is 83 years old, a widow. Her hands, once long and slender like my own, are blotchy, veined, and knotted with arthritis. They are

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shaking so badly that I have to hold the book for her, open at the page where the above lines by poet Robert Browning appear.

She reads slowly and jerkily, with obvious difficulty. Then I notice her gaze shift almost imperceptibly to some distant point in the visitors' lounge. She says nothing, but I know what she is thinking.

She is remembering the husband of 61 years who died four years ago when he fell and hit his head against a park bench just a block from the nursing home, the children and grandchildren she hasn't seen since they made the trip from Montreal and Los Angeles last Christmas, and the cello she hasn't been able to play since her crippled joints forced her to give up a concert career almost 30 years ago.

Her eyes are moist and angry when she eventually turns back to me. "Poets—they're all fools," she says. "What he writes there—it isn't true."

No, it isn't true. In fact, for the elderly today Browning's words contain the bitterest kind of irony. Old age is not the best time of our lives; more often than not it is the worst. The mythology of the "Golden Years" is only one of the ways we have devised to reject the realities of growing old and to shield ourselves from the painful truth of our own mortality.

The Threat of Creeping Agism

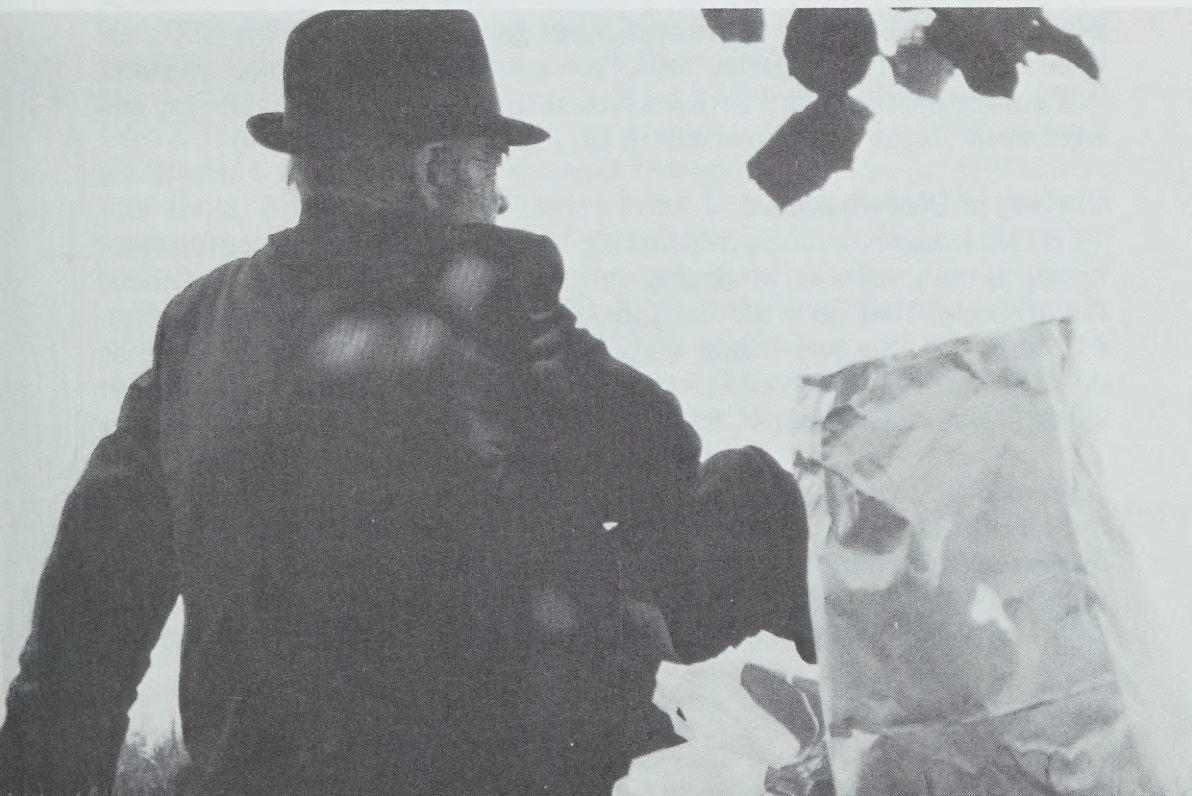
Aging is a process none of us can escape, yet we try valiantly to do so. We are careful not to look into the eyes of old people when we pass them in the street. We arbitrarily flush them out of the mainstream of day-to-day living and assign them to an obscure existence with no defined purpose or importance. We feel compromised by their demands for care and dignity, and look for ways to transfer our responsibility for their well-being. We belittle them with false assumptions about their capacity to think and feel as normal human beings. In short, we try our damnedest to ignore them.

In his most recent book, *A Good Age,* gerontologist Alex Comfort warns that creeping agism—discrimination against the elderly—threatens to make the aged unpeople by depriving them of dignity, money, proper medical services, and useful work. In a society such as

ours, where attitudes toward the aged constitute what Dr Comfort terms a "quiet sort of pogrom," is it any wonder the alcohol and other drug-related problems of the elderly are neglected?

Essential Insights

To confront them, after all, requires that we first confront our own fears and misconceptions about growing old, and that we learn to accept old age as an inevitable and natural stage of human development. These insights are essential because alcohol and other drug abuse among the aged are intricately interwoven with the process of aging itself. They are also urgent in view of the fact that by the year 2000, only 23 years from now, the size of the elderly population in both the U.S. and Canada will have doubled in relation to the general population. Added to that are the problems implicit in the dramatic increase in alcohol and other drug consumption rates among those entering middle-age today. Without a clear understanding of the unique nature of alcohol and other drug abuse among the aged, we cannot begin to deal with the existing evidence of their dependency problems, least of all prepare ourselves for the ominous difficulties which loom down the road.



Alcohol — The Most Abused

The evidence suggests, not surprisingly, that alcohol is the foremost substance of abuse by the elderly, followed by drugs obtained legally through prescriptions and over the counter. Illicit drug use is not unheard of, but its incidence is small, a fact explained in part by the "maturing out" of narcotic addicts after age 45 and the inability of older people to meet the economic costs of a sustained habit.

"Alcoholism and other types of alcohol abuse constitute a major health and social problem for the elderly," says Eloise Rathbone-McCuan, director of Baltimore's Levindale Geriatric Research Center. "The enormous task of identifying and treating the elderly alcoholic and problem drinker begins with the recognition that the problem exists. For too long, the specialized needs of this group of alcohol abusers have been ignored by all levels of the service network."

Different Set of Problems

A 1976 study of the alcohol-related problems of Ottawa's aged supports the thesis that the elderly drinker presents a special case. More than half of the 85 social agencies which responded to a questionnaire reported that the stresses of aging—resulting from both physical changes and society's treatment of its senior citizens—make the alcohol problems of the elderly different from those of other groups. How they are different becomes readily apparent with a close analysis of the peculiar difficulties older alcohol abusers face at the recognition, diagnosis, and treatment stages in the resolution of alcohol problems.

Variety of Disturbances

"The treatment of problem drinking in elderly patients is complicated by the sometimes overwhelming variety of physical, mental, and social disturbances that go with the process of aging," says Dr Rathbone-McCuan. At the two initial stages in particular, complications arise when indicators of alcohol abuse are mistaken for signs of senility or chronic brain symptom (CBS).

Age-specific factors such as the higher incidence of physical illness; reduced intellectual and physical capabilities; malnutrition; falls; and increased vulnerability to psychiatric disorders resulting from these and other conditions including social isolation, economic deprivation, retirement, loneliness, boredom, the loss of loved ones, reduced sexual

potency, and a sense of purposelessness can all be misread and dismissed as natural phenomena. Several studies have illuminated the similarities in symptoms between elderly alcoholics and non-alcoholics suffering deterioration of cerebral function (CBS) due to advanced age, making accurate diagnosis of alcoholism difficult for clinicians who are not well-versed in geriatrics.

The fact, too, that a large proportion of the aged live alone, without the support of family and friends and often with some physical infirmity, hampers the recognition of alcohol-related problems. Because of this, the task of detection often falls heavily on the shoulders of "outreach" social service personnel and physicians. Dr Rathbone-McCuan's estimate that one-third of the non-institutionalized population over 65 visit a doctor once a month underlines the crucial part played by the medical profession in discovering drinking problems. For those reluctant or unable to venture out on their own to seek help, the visiting public health nurse may be the only hope for detection.

No Strict Definition

A research team at the Rutgers University Center of Alcohol Studies also warns against the tendency to apply strict definitions of alcoholism to the elderly. This derives, in part, from the theory that there are at least two distinguishable types of geriatric alcohol abuser who may have nothing in common beyond a diagnosis of alcoholism. One has a lengthy history of alcohol problems; the other began drinking heavily late in life. Although the assumption is generally made that the latter group's distress is a response to life changes brought on by aging, Alcoholism and Drug Abuse Institute director Marc Schuckit of Seattle cautions against it. "The vast majority of people undergoing these stresses do not develop substance abuse. Also, abuse of alcohol can intensify somatic problems, isolation, and loss of status which tend to occur in older individuals in the first place." The co-existence of life problems with evidence of alcohol abuse does not prove a causal relationship, says Dr Schuckit. "There exists the same danger of assuming that because something makes sense, it is true."

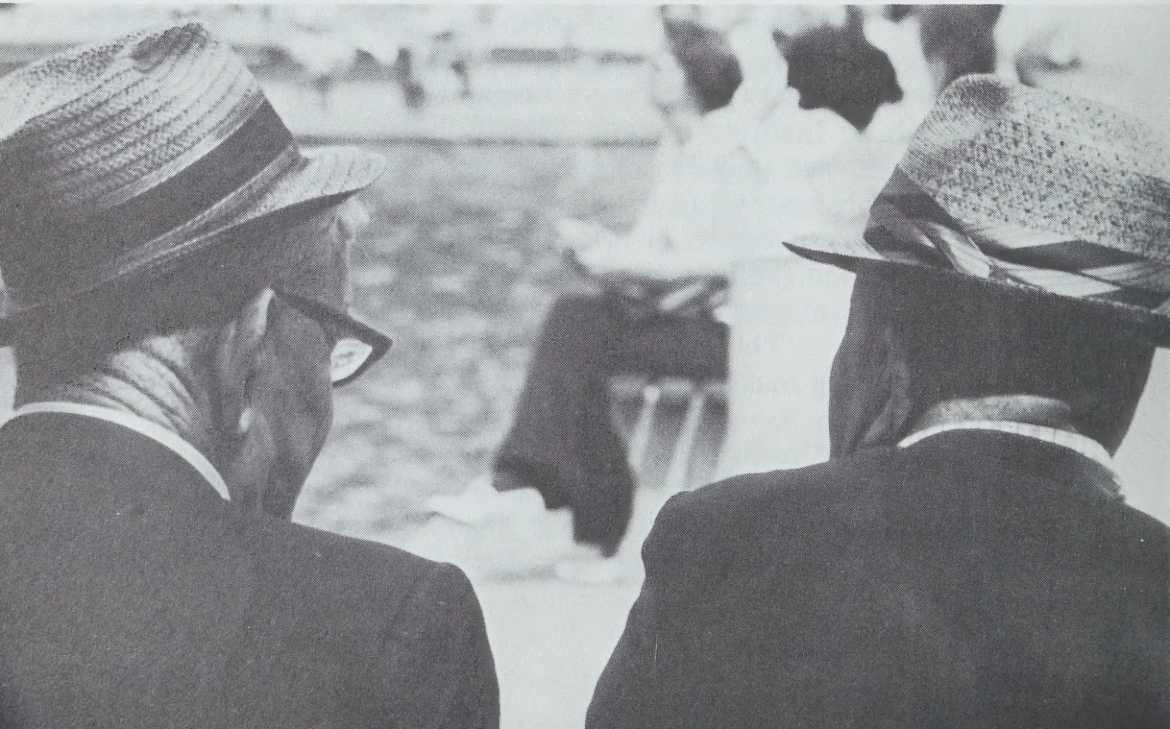
Peak Periods of Alcoholism

A major prevalence study of alcohol problems in the community 12 years ago established that alcoholism peaks between the ages of 45 and 54 and again from 65 to 74. It has also been acknowledged that elderly

drinkers generally consume less than their more youthful counterparts. Not only do lack of money, a changed social pattern, and decreased desire for alcohol combine to reduce social drinking among the elderly, but tolerance to both alcohol and drugs diminishes with the metabolic changes that accompany the aging process. "The chances of a person over 55 years of age being an alcoholic in the clinical sense of the word are minimal," the Rutgers group told the Alcohol and Drug Problems Association of North America in 1973.

Trouble with Attitudes

Attitudes play an important, and sometimes decisive, role in diagnosis and treatment. Symptoms of alcohol abuse are frequently obscured in elderly patients admitted to hospital for treatment of acute physical ailments as a result of concealment by the alcoholics themselves or their family. "Denial is infinitely greater in the elderly," says Addiction Research Foundation of Ontario medical consultant Dr Sarah Saunders. "Most of them weren't brought up to deal with their emotional problems, and they often view alcoholism as a sin." Many physicians and family members look upon alcohol as the only pleasure left to the aged and are reluctant to regard its abuse as a problem. This attitude is probably the most common, say addiction specialists, and also the most insidious.



"Many people refuse to see the suicidal behavior behind much of senile alcoholism," says gerontologist Alex Comfort from the Institute of Higher Studies at Santa Barbara. "They don't seem to think it matters if old people are hurting themselves. Relatives often encourage elderly family members to drink because it keeps them occupied and out of the way. They fill old people with depressants like alcohol and tranquillizers to keep them quiet."

"Poor Risk" Label

Because many nursing homes refuse to admit patients with a record of alcohol abuse, physicians sometimes bow to the wishes of family members to omit a diagnosis of alcoholism from applications made on behalf of elderly patients. There are doctors, as well, who see both old age and alcoholism as "incurable" and back away from the task of determining a treatment program and following it through.

If elderly problem drinkers are fortunate enough to have their distress detected and diagnosed, they still face a large number and range of treatment barriers. Not the least of these is the fact that existing services for alcohol abusers are not designed to accommodate elderly drinkers. "They will be accepted in some treatment programs," says Dr Saunders, "but they are not likely to be treated in a way which recognizes the problems unique to them. Many facilities have an unspoken cut-off point of 65. They feel it's not worthwhile to treat someone over that age, particularly if resources are limited. They'd rather treat a younger person because he or she has more potential following recovery. I get pretty upset when I hear that. I don't care what age a person is; if he's in distress and needs help, you help him."

Rutgers researcher Bruce Carruth stresses that the small number of older people appearing in studies of treatment populations is no indication of the extent of the problem of pathological drinking among the aged. Rather, it reflects the exclusion of the elderly from treatment programs because they have been labeled "poor risks."

Few Special Facilities

As for treatment facilities which address themselves directly to the special problems of older drinkers, there are only a few scattered across the continent. And this despite the fact that 83% of the community care providers surveyed by Rutgers four years ago expressed the conviction

that the issue of alcohol abuse among this age group was urgent enough to warrant public policies and specialized programs. The treatment model Dr Saunders developed in 1974 for alcoholics at Toronto's Castleview-Wychwood Home for the Aged is "virtually the only one of its kind I am aware of in Canada," she says. "If there are more, people are certainly keeping quiet about it." The void of both treatment facilities and statistics in this area is indicative of a problem which has been obscured by neglect, she feels. "The problems of the elderly simply do not have a high priority. The employed alcoholic, the impaired driver, young people, and women are all given much more attention."

Inadequately Trained Personnel

The lack of adequately trained personnel is another determinant of both the availability and efficacy of alcoholism treatment for the aged. "The professional education of social workers—like that of doctors, psychologists, and nurses—normally includes little or no information about alcoholism, and little or no training in the special skills involved in the treatment of the alcoholic client," says Grace Duckworth, supervising social worker at San Diego's Adult Protective Services agency. Adds Dr Saunders: "The treatment of alcohol-related problems has so many social components to it that it's hard for scientifically-oriented people to accept it as a problem they ought to deal with. Older nurses, in particular, tend to feel their role is merely to tend to a patient's physical needs."

Compounded with an inadequate knowledge of geriatrics, the result is that elderly alcoholics receive fewer days of hospital care and are transferred sooner and more often to nursing homes. If accepted there, they are just as unlikely to encounter personnel willing or able to advance their recovery prospects. In a study conducted last year by Carleton University graduate student Paul Welsh for the Canadian Foundation on Alcohol and Drug Dependencies, three-quarters of the residential and institutional facilities surveyed reported it was necessary at times to evict or transfer elderly individuals because of their drinking behavior. Dr Rathbone-McCuan also notes that residential settings, whether designed for short or long-term stays, are geared for younger homeless men, chronic "skid row" drunks, or—to a smaller extent—women.

"It is imperative for physicians to familiarize themselves with the various degrees and manifestations of problem drinking in the elderly

in order to make a proper match between the patient and the treatment resource," says Dr Rathbone-McCuan. In the event a patient's excessive drinking was precipitated or aggravated by the death of a spouse, for example, "treatment should be directed toward helping the aged person work through the feelings of loss. Efforts will be less effective if the focus is solely on the coping behavior and not on the source of the emotional stress." The small number of doctors sufficiently trained in geriatrics to make these distinctions is another obstacle to treatment. Says psychiatrist Sheldon Zimberg in a 1973 article entitled "The Elderly Alcoholic": "The unwillingness of physicians to designate a patient as an alcoholic, and the general feeling of helplessness about treating alcoholics is a very important part of the problem." As well, the many social and health services required to deal effectively with the problem of excessive drinking are largely fragmented and uncoordinated, resulting in the older person being passed around from one agency to another. The possible existence of cardiovascular difficulties in the aged person further complicates the treatment picture since Antabuse and Temposil cannot be administered.

High Incidence and Prevalence

Because of the hidden nature of alcohol abuse among the elderly, a reliable estimate of its incidence and prevalence has been hard to determine. Most addictions personnel working in this area, however, seem to accept the Rutgers figure of 7.5% of the over-55 population who experience some degree of distress directly related to excessive consumption. This translates to fully one-third of the total number of problem drinkers. It also evokes the virtually universal opinion that alcoholism and alcohol-related problems among the aged are far more prevalent than previously believed. Several factors besides the lack of treatment statistics have prevented an accurate picture from emerging.

Firstly, there is no uniform figure indicating the onset of "old age" upon which health care professionals agree. Research undertaken thus far has used a variety of ages from 50 through 65 to distinguish when this stage of development begins. Many investigators think 50 is too early; others feel 65 is too late. Researchers have also utilized widely disparate definitions of alcohol abuse to determine its incidence. Some have accepted survey respondents' own criteria for "alcoholism" while others have used the American Medical Association disease definition, actual diagnoses, or a sliding scale of alcohol abuse such as

that used by Dr Zimberg in a 1971 study conducted at the Harlem Hospital Center in New York. Furthermore, most prevalence studies have taken place in institutional or clinic settings and therefore deal with a limited segment of the elderly population—often those with existing medical or psychiatric problems which may or may not be related to excessive drinking.

From his 1975 review of the alcohol problems of the elderly, University of Washington psychiatrist Marc Schuckit concluded that up to 20% of older inpatients and 10-15% of older outpatients have serious difficulties resulting from alcohol abuse. He also estimates about 10% of all alcoholics undergoing treatment are over 60. Last year two U.S. researchers found 90% of the patients over 55 receiving help from a storefront clinic in the Bowery section of New York had a history of alcoholism; the same group comprised 40% of all clinic patients seen within a recent 21-month period. James F. Rooney of the Catholic University of America School of Social Service says studies indicate more than two-thirds of all skid row alcoholics are over 50 and a third of those are over 60.

Retirement Community Syndrome

While little attention has been paid to retirement communities, there is a strong feeling among many addictions personnel that alcohol is fast becoming a serious problem in these settings. Gerontologist Alex Comfort reports that administrators at one California development recently told him the problem has reached "colossal" proportions. Don Hickerson of the Alcoholism Council of Southern Arizona says the very nature of the retirement community adds to the likelihood of alcohol abuse: "You play bridge, you have a drink. You play golf, you have a drink. These people have idle time and they generally don't have to drive. They have good incomes and don't have to show up for work or be responsible to anyone." At St Luke's Hospital in Phoenix, up to a third of the alcoholism patients are over 55 and most are retired. The "Top of the Hill" treatment program there is one of the few designed to meet the specific needs of the elderly alcohol abuser.

The Problem at Large

Few studies exist which indicate the extent of alcohol problems among the elderly at large. Perhaps the most widely quoted is a 1965 survey conducted in a suburb of Manhattan called Washington Heights which

found that 5.1% of those over 65 suffered from "alcoholism." Another door-to-door survey done in San Francisco showed 19.5% of men and 2% of women over 60 were considered heavy drinkers. Research of most kinds has consistently shown a higher incidence of alcohol abuse among men, and a higher rate yet among elderly widowers and separated or divorced men.

Caseload surveys of social service agencies have also turned up figures to substantiate the existence of a heretofore hidden problem. In his study for the Canadian Foundation on Alcohol and Drug Dependencies, Paul Welsh found that virtually every agency responding to his questionnaire had seen elderly clients with alcohol problems, and more than half reported a rate of 10% or more. A recent Rutgers study got similar results.

Mandate for the Community

Statistics on deaths from alcohol-related causes are another measure of concern. Between 1969 and 1973, the death rate for women over 60 from the toxic effects of alcohol rose 500% in Canada; during the same

period, the death rate from alcohol combined with other drugs in the same group increased by 67%. Cirrhosis of the liver due to alcohol abuse created an increase in deaths of 106% in men and 172% in women over 60 in Canada between 1965 and 1973.

"Evidence of the extent of the problem is a mandate for the community to act to relieve the pain and suffering of a substantial number of older [people]," advocates Rutgers researcher Bruce Carruth. Among his recommendations: the creation of task forces to develop goals and priorities, the implementation of methods to identify and treat elderly alcohol abusers, and the development of procedures to monitor and evaluate programs.

High Prescription Use

The same physical, mental, and social stresses of aging play a major role in the pattern of drug use other than that of alcohol among the aged by exposing them to a greater number and variety of drugs for potential abuse. Georgia State University sociologist David Petersen says data for prescription drugs alone reveal that those over 65, while comprising roughly one-tenth of the population, receive a quarter of all prescriptions written. "One can assume that they also consume an equally substantial proportion of over-the-counter drugs," he adds. Indeed, the U.S. National Council on Aging reported in 1970 that the elderly spend an estimated 20% of their out-of-pocket health expenditures on drugs. According to New York psychiatrist Emil Pascarelli, one of the foremost researchers in this area, the over-55 group consumes more legal drugs than any other segment of society. The number of prescriptions scripted for this group in the U.S. now totals more than 225 million annually, of which 80% are for mood-altering substances. Not surprisingly, the prescription drugs most frequently abused by the elderly are sleeping pills.

And Abuse

While it has been found that most prescriptions are warranted, the likelihood of abuse—whether intended or inadvertent—increases significantly when the following factors are considered. Firstly, the probability of an adverse drug reaction, even to a normal dose of medication, is double that of younger populations because of the lowered physical reserves of the elderly. As well, it has been shown the potential for adverse reactions swells in relation to the number of drugs an in-

dividual is taking and the complexity of the prescription directions. The elderly make a high degree of error in drug consumption as a result of lack of information and confusion arising from multiple prescriptions. One study of older patients attending a medical clinic found 66% had made mistakes in taking medications as prescribed. This problem is further complicated by the fact the aged are more likely to mix prescription drugs with over-the-counter remedies or alcohol. And added to this is a tendency to accumulate medications of all kinds—often long beyond their expiry date—and to share them freely with elderly friends and neighbors. Dr Comfort recounts a British study which investigated the borrowing patterns of the elderly and found one individual with 42 different medications in his collection.

Physicians' Guilt

This "formidable array of drugs" also results, at least in part, from loose prescribing methods by physicians untrained in geriatrics who find it simpler to medicate the symptoms of aging rather than treat them, or who fail to appreciate the effects of multiple drugs on the elderly. Says Vancouver psychiatrist J. C. Morrant: "In hospitals and nursing homes, the over-prescribing is surprising. A prescription chart may list a hypnotic, an anti-psychotic or two, an anti-Parkinsonian agent, a cardiac glycoside, a form of potassium supplement, a diuretic or two, a vasodilator, an assortment of analgesics (often proprietary ones containing several ingredients), vitamins, hormones, and sometimes three different aperients. . . .This *furor therapeuticus* reflects the physician's guilt at being unable to cure the incurable."

The hazard in such prescription techniques, according to Dr Morrant, lies in the fact that most prescription drugs and many over-the-counter drugs can cause psychiatric symptoms as a side effect in aged patients. Abuse of over-the-counter medications such as analgesics (aspirin compounds), antihistamines (Benadryl, Dramamine), anticholinergics (found in virtually all proprietary nerve remedies), and those containing bromide (Sominex, Nytol, Bromo-Seltzer) has been linked with depression, confusion, agitation, drowsiness, and even toxic psychosis. Surveys have found, in fact, that analgesic abuse tends to increase with age in both men and women.

Crucial and Vexing Aspect

When prescribed in too-large or too-frequent doses, or consumed in combination with other substances such as alcohol, many drugs pro-

voke new symptoms more onerous than the ones they were meant to alleviate. And worse, the new symptoms risk being misconstrued as further evidence of senility rather than as an adverse drug reaction.

Less-than-stringent prescription practices can also contribute to accidental and intentional drug overdoses among the elderly. For, as British researcher A. J. Smith says, the drugs chosen by the aged to commit suicide "are probably dictated not by the patient's knowledge of pharmacology, but by simple availability." This is underscored by findings which indicate more than three-quarters of suicide attempts by the elderly are made with drugs obtained from their own physicians. In their 1975 review of elderly suicide, University of Southern California School of Medicine researchers Roger Benson and Donald Brodie stressed the likelihood of physical illness existing in old people who attempt suicide. "There is no doubt that serious physical disease is a factor in influencing a decision to take one's life at any age," they note. In the elderly, where it is manifested most often in diseases of the cardiovascular system, it has been identified in up to 60% of cases.

The acute drug reaction—whether inadvertent or deliberate—is "one of the most crucial and vexing aspects" of drug abuse among the aged,

according to sociologist David Petersen. His 1972 study of 1,128 patients admitted to Miami's Jackson Memorial Hospital with diagnosed drug overdoses showed that sedatives and minor tranquillizers were involved in four of five cases where patients were over 50. "The significance of these drugs as causal agents in the majority of accidental overdose and suicidal gesturing cases cannot be denied," says Petersen. Of the 30 different medications identified as contributing to overdoses among the older group, the most frequently abused were Valium, Tuinal, phenobarbitol, and Darvon, a non-narcotic analgesic.

"Probably one in 10 people over the age of 60 are drug abusers," Marc Schuckit told the California Medical Association recently. "Physicians should have a high index of awareness of the abuse of sleeping pills, anti-anxiety drugs, anti-depressants, and stimulants in older people." He himself feels "very strongly" that amphetamines should never be prescribed for elderly patients, and that other mood-altering drugs should be warranted only rarely. Adds Vancouver psychiatrist J. C. Morrant: "Barbiturates in the elderly should go the way of bromides—into the dispensary trash can."

Young Addicts Grown Old

The pattern of drug use and abuse among the aged is distinguished by the fact that most substances are legally manufactured and legally obtained. There exists, however, a small number of illicit drug addicts who have escaped death and failed to "mature out" of their addiction only to arrive at old age with their habit virtually intact. "The geriatric opiate abuser is usually the young addict grown old," says Dr Schuckit. But with a few differences. For one thing, elderly addicts tend to use smaller quantities of drugs and to take them less frequently than younger addicts. Less than 5% of elderly drug abusers in a 1972 study reported using drugs daily. Older opiate addicts are also more likely to seek substances other than heroin, partly to avoid physical hazards resulting from impurities, and partly because they are less able or willing to engage in the kinds of activities necessary to sustain a heroin habit. This has been confirmed by research showing almost two-thirds of a sample group of elderly addicts used Dilaudid while only 19% took heroin. These factors are thought to explain a lower rate of drug overdoses among older opiate abusers. Elderly addicts tend as well to be more difficult to identify, not only because they are often isolated

socially or hidden by their families, but because police routinely overlook their involvement in minor crimes.

Out of Sight and Out of Mind

Although few studies have attempted to determine the prevalence of serious addiction problems among the aged, researchers estimate 5% of methadone maintenance patients are 45 or more, and 1% are over 60. Interestingly, 61% of Britain's registered drug addicts were 50 or more in 1960. By 1969, the same age group comprised only 8% of the total. A similar trend has been noted in North America in the wake of escalating drug abuse by the young. Appearing now, too, is increasing evidence some elderly opiate addicts may have begun abusing drugs in their 40s rather than during their youth.

Noting that older addicts generally go into therapy with a greater incidence of accompanying medical problems, Dr Schuckit nevertheless stresses their recovery prospects: "The older individual is more likely to stay in therapy longer and to complete treatment, which may indicate a better overall response." Ironically—in view of the reluctance of many to engage elderly alcoholics in active treatment—they, too, have demonstrated a consistently superior response to rehabilitation than their younger counterparts. Optimistic as that sounds, it is little comfort to those elderly alcohol and drug abusers who, being out of sight and mind, are also out of the recovery stakes.

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